Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 6-7-01 through 3-12-02.
   b. The request was received on 6-4-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFAs
   c. EOBs
   d. Example EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to Request for Medical Dispute Resolution
   b. HCFAs
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 8-2-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 8-5-02. No fourteen (14) day response was noted in the dispute packet. The Carrier's three (3) day response is reflected as "Exhibit II" in the Commissions case file.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 2-13-02:
   "This claim is being resubmitted for reconsideration due to the payments on the claims being paid inconsistently. According to our payment records date of service 12/5/12/2001 [sic] in the amount of $375.00, we were paid only $264.27 leaving a balance of $110.73 and were not paid at the Full Billed [sic] amount. This claim is being

resubmitted because we billed for the 'PURCHASE' of a Walker w/seat Rollator, Shower chair, Shower Head/Hose and a fully Electric Hospital Bed. This claim should not have been reduced. We fell [sic] that you have processed this claim in error. The D.M.E. Fee Guideline clearly shows that the allowable for purchase is the reasonable we billed for on the HCFA-1500…. We the provider are billing this equipment at a Fair and Reasonable amount there for [sic] the claim should not be reduced."

2. Respondent: Letter dated 8-19-02:
"The Respondent has developed and consistently applies a methodology to determine a fair and reasonable reimbursement amount to ensure that similar procedures provided in similar circumstances receive similar reimbursement…. Regardless of the Carrier's methodology, the burden remains on the Provider to show that the amount requested is fair and reasonable. The Requestor has failed to meet its burden. The file does not give a sufficient cost-basis upon which it can base its bill. The Requestor has done nothing more than submit a laundry list of charges, without one shred of justification for the prices contained therein…. The Requestor supplies a number of EOBs from other carriers, which more than likely show higher payments, proof of payment from other EOBs does not support the reasonableness of the fee. Attaching a few selected EOBs is nothing more than "cherry-picking," choosing only those bills, which were reimbursed at a higher rate to justify the costs. The willingness or accidental payment by certain carriers to reimburse at or near the billed amount does not document that the billed amount is fair and reasonable, does not show that effective medical cost control has been achieved, and certainly does not consider the security of payment."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 6-7-01 through 3-12-01. No EOB was noted for HCPCS Code L0960 for date of service 6-8-01 and therefore will be dismissed.

2. The carrier denied the billed services as reflected on the EOBs as, "M – No MAR/Reduced to Fair and Reasonable; F – Reduced According to Fee Guidelines".

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
6-7-01 6-7-01 12-11-01 1-10-02	E1399 E1399 E1399 E1399	$ 75.00 $155.00 $112.00 $134.95	$ 63.75 $131.75 $ 95.20 $114.70	M M M M	DOP	Rule 133.307 (g) (3) (D), (E); Section 413.011 (d); HCPCS descriptor	The carrier has denied the disputed equipment as, "M-No MAR/Reduced to Fair and Reasonable". Section 413.011 states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." The provider failed to support its position that the fees charged were fair and reasonable as required by Rule 133.307 (g) (3) (D). The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The reimbursement data evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" The provider submitted EOBs from other carriers. None of the EOBs submitted identified the disputed HCPCS Code. Each example EOB for the HCPCS Code E1399 recommended reimbursement amounts by other carriers. The provider did not submit definitive information to identify that the charges reflected on the example EOBs are the same as durable medical equipment billed for dates of service in dispute. CPT Code E1399 is defined as "Durable medical equipment, miscellaneous". As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. Without documentation to support what the miscellaneous HCPCS Code E1399 represents on the EOB, the provider failed to meet the criteria of Rule 133.307 (g) (3) (D) by submitting insufficient documentation to establish that the payments made by the carrier were not fair and reasonable. Therefore, **no additional** reimbursement is recommended

6-8-01	L0565-52	$450.00	$382.50	M	DOP	Rule 133.307 (g) (3) (D), (E); Section 413.011 (d); HCPCS descriptor	The carrier has denied the disputed equipment as, "M-No MAR/Reduced to Fair and Reasonable". Section 413.011 states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." Per Rule 133.307 (g) (3) (D), the provider failed to support their position that the fees charged were fair and reasonable as required by Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Provider only submitted one example EOB. One example EOB is not sufficient evidence to support that the charges represent fair and reasonable. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider has failed to discuss, demonstrate and/or justify that the payment being sought is fair and reasonable. Therefore, **no additional** reimbursement is recommended.
12-11-01 12-11-01	E0145-NU E0245-NU	$495.00 $110.00	$420.75 $ 93.50	M M	DOP DOP	MFG GI (VIII) (A); HCPCS descriptor	The "NU" modifier is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the DME in dispute. Therefore, **no** additional reimbursement is recommended.
12-12-01 1-12-02 3-12-02	E0265-RR E0265-RR E0265-RR	$235.50 $235.50 $235.00	$200.18 $204.25 $204.25	M F M	DOP DOP DOP	MFG GI (VIII) (A); HCPCS descriptor	The "RR" modifier is recognized by the Commission when billing for postoperative monitoring. This descriptor is not utilized when billing HCPCS Codes. For this reason, MRD is unable to determine proper reimbursement for the DME in dispute. Therefore, **no** additional reimbursement is recommended.
Totals		$2,323.45	$1,983.08				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 06th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

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VII. Dismissal

HCPCS Code L0960 for date of service 6-8-01 is being dismissed. Commission Rule 133.307(e) lists the required components for a complete request for medical dispute resolution. Section (e)(2)(B) requires "a copy of each explanation of benefits (EOB) or response to the refund request relevant to the fee dispute or, of no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB".

Commission Rule 133.307 (m) provides when the Division may dismiss a request. Sections (m)(6) supports that, "The Commission may dismiss a request for medical fee dispute resolution if…the commission determines that good cause exists to dismiss the request."

No EOB was noted for HCPCS code L0960, date of service 6-8-01. EOBs are required to determine the reason for denial. Without some evidence as to how/why the service were denied, it is not possible to render a decision.

Therefore, it is the conclusion of the Medical Review Division that this HCPCS Code for date of service 6-8-01 be dismissed without any additional action being taken.

Pursuant to Commission Rule 133.307 (m), "A dismissal does not constitute a decision."

The above DISMISSAL is hereby issued this 06th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Dispute Resolution Section
Medical Review Division